United States Senate
WASHINGTON, DC 20510

July 31, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Verma,

We share the goal of ensuring that Medicaid beneficiaries receive quality care that meets their needs and promotes healthy outcomes. It is for that reason that I am requesting that you evaluate the information contained in a document that I received from Centene Corporation, to ensure that the company is meeting this goal and acting as a good steward of federal and state resources. Specifically, I urge you to examine the service approval and coverage denial policies and practices of Centene Corporation and their subsidiaries to ensure compliance with all applicable rules and regulations.

Last year, the *Dallas Morning News* published an award winning investigative series that describes the catastrophic health outcome for a child, named D'ashon Morris, as well as the health conditions of several other individuals. The series questions the coverage decisions made by Superior Health, a Medicaid managed care plan and subsidiary of Centene Corporation. Centene Corporation recently shared with me the attached document, titled "Medicaid Managed Care Organization Inquiry & Centene, The Dallas Morning News Got it wrong" challenging the accuracy of that reporting. While this document represents a callous response to a tragedy, it also may have implications for other Medicaid enrollees under Centene's care. For example, the document seems to indicate that the service provided to one individual can be dependent on the level of care provided to another individual, in this case, a sibling. It also suggests that the care provided by a guardian is sufficient in place of a health care provider. Further, it implies that the cost of care factors into decision-making when evaluating the approval and denial of services. These justifications are troubling and suggest that policies across Centene Corporation's numerous subsidiaries and plans should be evaluated further. On July 30, 2019, I met with the CEO of Centene, Michael Neidorff, to share these concerns. During the meeting, he made statements that were consistent with the information outlined in this document.

The attached document also calls into question whether CMS has adequately ensured that Medicaid managed care organizations and companies are adhering to all applicable rules and regulations, many of which protect beneficiaries with complex medical conditions or disabilities. Indeed, CMS has indicated that it would apply "enforcement discretion" pertaining to 2016 rules

regarding Medicaid managed care.[1] In practice, I am concerned that more limited oversight is fostering an environment that allows some Medicaid managed care companies to put profits ahead of patients. And, while I am pleased that the HHS Inspector General has agreed to investigate issues within the managed care appeals system at my request, that work does not replace regular and routine oversight by CMS.[2]

To help me better understand the steps that CMS took to address the findings of the *Dallas Morning News* investigation, as well as the actions that CMS is taking to ensure proper oversight of Medicaid managed care, I request the following information:

1) Please provide a detailed description of CMS' routine Medicaid managed care oversight policies and procedures to ensure states operating managed care programs are doing so in accordance with federal law and regulation. Please provide any documents related to those routine practices, including checklists, policies and procedures and contract reviews;
2) In its routine oversight of Texas' managed care program, did CMS find any issues related to Texas' management of its managed care program, including the allegations raised in the *Dallas Morning News* series? If so, please provide any written assessments of CMS' review. If not, when did CMS learn of these allegations?
3) Did CMS staff conduct a review of the findings and documents uncovered by the *Dallas Morning News*? If so, please provide the date of that review;
4) Did this review result in a written assessment of the allegations? If so, please provide that assessment;
5) Did CMS engage with the state of Texas, or any other state regarding the *Dallas Morning News'* findings? If so, please provides the dates of contact, any electronic or physical correspondence conveyed or received, and any documents that were produced as a part of this consultation;
6) Did CMS engage with Superior or its parent company Centene regarding the allegations in the *Dallas Morning News* series? If so, please provide the dates of those interactions, including any correspondence, phone calls or meetings, and please provide any written materials that were produced during that engagement;
7) Did CMS engage with other Medicaid managed care plans in Texas regarding the allegations in the *Dallas Morning News* series? If so, please provide the dates of those interactions, including any correspondence, phone calls or meetings, and please provide any written materials that were produced during that engagement;
8) Did the staff at CMS discuss the issues raised by the *Dallas Morning News* internally, or with CMS or HHS leadership? If so, please provide the dates, times and agendas and materials for any internal or external meetings that took place on this topic;

[1] Centers for Medicare and Medicid, CMCS Informational Bulletin: Medicaid Managed Care Regulations with July 1, 2017 Compliance Dates (Jun. 30, 2017) (https://www.medicaid.gov/federal-policy-guidance/downloads/cib063017.pdf).

[2] Letter from Senator Casey to HHS Office of Inspector General (April 4, 2019); HHS Office of Inspector General, Work Plan, Medicaid Managed Care Organization Denials (April 2019) (https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000370.asp).

9) Did CMS take any corrective action against related to Texas's Medicaid managed care program between FY 2016 and FY 2019? If so, please provide any documents including corrective action plans and summaries of desk or site reviews related to that action.

As you know, I have been working to ensure that individuals and families across the country continue to have access to the benefits to which they're entitled through Medicaid. The concerns that I express in this letter are very much in line with the concerns that I maintain about efforts by CMS to allow states to restrict access to Medicaid.

As such, I am requesting that CMS review this matter and respond by August 20, 2019 with your recommendation as to what steps Superior, other Centene Corporation subsidiaries and all Medicaid managed care companies can take to avoid outcomes like those reported on in the *Dallas Morning News* and whether any corrective action is warranted.

Additionally, I ask that you provide the above information as well as a briefing on CMS's findings as soon as possible, but in no event later than August 20, 2019.

Thank you for your attention to this matter and I look forward to your prompt response.

Sincerely,

Bob Casey

Robert P. Casey, Jr.

Attachment: Document from Centene Corporation titled: "Medicaid Managed Care Organization Inquiry & Centene, The Dallas Morning News Got it wrong"

CC: HHS Office of Inspector General

Medicaid Managed Care Organization Inquiry & Centene

The Dallas Morning News Got it Wrong

DALLAS MORNING NEWS ***ASSERTION***	***FACT***
1. Member should have had 24x7 care	a. Had 17 hours per day of 1-on-1 RN care, paid for by Superior Health b. Had a foster mother who was a Licensed Vocational Nurse, paid for by the State of Texas c. Member lived with his twin sister, who had 24x7 1-on-1 RN care, paid for by Superior Health d. No administrative appeal was filed after Superior's approval of 17 hours per day of 1-on-1 RN care
2. Member lacked care at time of incident	a. A Licensed Vocational Nurse was in the room at the time of the incident b. A RN and a Certified Nursing Assistant ran the respite house; both were present at the time of the incident c. Member's usual RN, paid for by Superior, was set to arrive at 7 AM, a few minutes after the incident
3. It is OK to let a toddler repeatedly pull out his trach; a nurse just needs to put it back in	a. The standard of care is PREVENTION; pulling out a trach harms the toddler each time it is pulled out because it creates scar tissue b. The standard of care is the use of a medical elbow brace (known as a "soft splint") to discourage a toddler from pulling out his trach; meant to protect the toddler from injuring himself c. Foster parent did not use elbow brace, leading to harmful pull-out-and-replace pattern d. It does not take 24x7 1-on-1 RN care to prevent a toddler from pulling out his trach
4. Superior Health neglected Member to make a profit	a. Superior Health's premium for an infant was $922 per month. The average annual expenditure for an infant in the Member's risk group was $109,000. Superior Health spent many times this amount on Member b. Superior Health also spent many times the annual average on Member's sister's health care during the same period, including providing 24x7 nursing c. Use of an elbow brace was appropriate, but was not followed